AmeriHealth Caritas Iowa

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Request for Prior Authorization

Buprenorphine/Naloxone

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

Prior authorization is required for oral buprenorphine or buprenorphine/naloxone. Requests for doses above 24 mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to three months. Requests for maintenance doses above 16 mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol, and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Requests for surgically implanted buprenorphine products will not be considered through the pharmacy benefit and should be directed to the member's medical benefit. Payment will be considered when the following is met: 1) Patient has a diagnosis of opioid dependence and is 16 years of age or older; and 2) Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" Drug Enforcement Administration (DEA) number; and 3) Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy; and 4) A projected treatment plan is provided with initial request (see below requirements). 5) Requests for renewal must include updated treatment plan and additional documentation as indicated below. 6) Documentation is provided that transmucosal buprenorphine will not be used concomitantly with the buprenorphine implant. 7) Requests for buprenorphine will only be considered for pregnant patients.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:
☐ Suboxone SL Film

Non-Preferred:
☐ Buprenorphine (Please verify patient is pregnant) ☐ No ☐ Yes
☐ Buprenorphine/Naloxone SL Tabs
☐ Zubsolv

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number: ☐ No ☐ Yes

Patient participates in and is compliant with counseling: ☐ No ☐ Yes Date of most recent counseling session:

Is patient using transmucosal buprenorphine with buprenorphine implant? ☐ No ☐ Yes

Initial requests

Include projected treatment plan. May attach treatment plan or provide at a minimum the below information:

Anticipated induction/stabilization dose:

Anticipated maintenance dose:

Expected frequency of office visits:

Expected frequency of counseling/psychosocial therapy visits:

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Renewal requests
Please provide the below information:

Updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self assessment scale. Date of most recent taper attempt:

Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last prior authorization request. ☐ No ☐ Yes Date reviewed:

Documentation of a current, negative drug screen. Date of most recent drug screen:

Documentation the patient has been compliant with office visits and counseling/psychosocial therapy visits.
Compliant with office visits? ☐ No ☐ Yes Date of most recent office visit:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.